FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040741

Facility Name: DEERBROOK CARE CENTRE

Address: 306 NORTH LARKIN AVE. (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (815) 744-5560 **Fax #** (815) 744-6914

IDPA ID Number: 36-3943427001

Date of Initial License for Current Owners: 04/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	214	Skilled (SNF)	214	78,324	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	214	TOTALS	214	78,324	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,836	1,431	11,216	20,483	8
9	SNF/PED					9
10	ICF	34,350	7,886	1,477	43,713	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,186	9,317	12,693	64,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.96%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/0/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 214 and days of care provided 7,469

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	265,828	23,770	13,656	303,254		303,254	(2,326)	300,928			1
2	Food Purchase		223,390		223,390		223,390	(1,637)	221,753			2
3	Housekeeping	131,123	36,538		167,661		167,661	118	167,779			3
4	Laundry	89,330	21,187	171	110,688		110,688	711	111,399			4
5	Heat and Other Utilities			153,180	153,180		153,180		153,180			5
6	Maintenance	84,659	34,989	49,998	169,646		169,646	(1,691)	167,955			6
7	Other (specify):*			15,929	15,929		15,929		15,929			7
8	**TOTAL General Services**	570,940	339,874	232,934	1,143,748		1,143,748	(4,825)	1,138,923			8
	B. Health Care and Programs											
9	Medical Director			9,150	9,150		9,150		9,150			9
10	Nursing and Medical Records	2,810,958	191,706	109,753	3,112,417		3,112,417	(69,965)	3,042,452			10
10a	Therapy											10a
11	Activities	192,619	12,476		205,095		205,095	(1,478)	203,617			11
12	Social Services	34,838			34,838		34,838		34,838			12
13	Nurse Aide Training											13
14	Program Transportation			130	130		130		130			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,038,415	204,182	119,033	3,361,630		3,361,630	(71,443)	3,290,187			16
	C. General Administration											
17	Administrative	154,231		827,932	982,163		982,163	(797,304)	184,859			17
18	Directors Fees											18
19	Professional Services			302,021	302,021		302,021	(189,794)	112,227			19
20	Dues, Fees, Subscriptions & Promotions			166,641	166,641		166,641	(147,882)	18,759			20
21	Clerical & General Office Expenses	374,201	32,814	54,935	461,950		461,950	158,215	620,165			21
22	Employee Benefits & Payroll Taxes			650,641	650,641		650,641		650,641			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,402	3,402		3,402	10,974	14,376			24
25	Other Admin. Staff Transportation			1,972	1,972		1,972		1,972			25
26	Insurance-Prop.Liab.Malpractice			266,353	266,353		266,353	24,527	290,880			26
27	Other (specify):*			250,307	250,307		250,307	(250,307)				27
28	**TOTAL General Administration**	528,432	32,814	2,524,204	3,085,450		3,085,450	(1,191,571)	1,893,879			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,137,787	576,870	2,876,171	7,590,828		7,590,828	(1,267,839)	6,322,989			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: DEERBROOK CARE CENTRE **#0040741** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,590	
	REPAIRS & MAINTENANCE		1,066	
			0	13,656
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		171	
			0	171
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		31,663	
	ELECTRICITY		79,290	
	WATER		42,227	
	CABLE TV - LOBBY		0	
			0	153,180
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,569	
	PAINTING & DECORATING		1,765	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		29,368	
	ELEVATOR MAINTENANCE & REPAIR		6,031	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,313	
	FIRE SERVICE		2,952	
			0	
			0	
			0	49,998
7	**OTHER**			
	SCAVENGER		15,929	
	SECURITY SERVICE		0	15,929
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,150	9,150

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	938	
	PHARMACY CONSULTANT	XVIII B 39-2	4,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	97,797	
	PSYCHOLOGIST	XVIII B 47-2	6,818	
			0	109,753
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DEERBROOK CARE CENTRE **#0040741** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		130	130
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	827,932	827,932
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	31,339	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	270,682	
			0	302,021
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	76,746	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	52,788	
	EMPLOYEE WANT ADS	XIX F	6,016	
	CONTRIBUTIONS	VI 20 XIX F	30	
	DUES & SUBSCRIPTIONS	XIX F	9,440	
	LICENSES & PERMITS	XIX F	1,656	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	11,660	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	7,709	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	596	166,641
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		4,692	
	EQUIPMENT REPAIR & MAINTENANCE		10,520	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	139	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		38,521	
	MESSENGER SERVICE		1,063	
			0	54,935

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	308,322	
	UNEMPLOYMENT COMPENSATION	XIX D	40,854	
	WORKERS COMPENSATION INSURANCI	XIX D	84,201	
	HOSPITALIZATION INSURANCE	XIX D	194,078	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,367	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,900	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	8,919	
	CHICAGO HEAD TAX	XIX D	0	650,641
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,209	
	TRAVEL	XIX G	193	
			0	
			0	3,402
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,972	1,972
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		266,353	266,353
27	**OTHER**			
	BAD DEBTS	VI 24	250,307	
				250,307

GRAND TOTAL COLUMN 3 OTHER 2,876,171

DEERBROOK CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	223,390	PATIENT MEALS	192588
LESS SALES TAX	(1,637)	ADD EMPLOYEE MEALS	0
NET FOOD	221,753	TOTAL MEALS/YEAR	192588
TOTAL PATIENT CENSUS	64,196	NET FOOD	221753
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	192588
TOTAL PATIENT MEALS	192588	COST PER MEAL	1.15
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number DEERBROOK CARE CENTRE #0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			82,475	82,475		82,475	209,214	291,689			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,222	4,222		4,222	203,490	207,712			32
33	Real Estate Taxes			87,357	87,357		87,357		87,357			33
34	Rent-Facility & Grounds			792,050	792,050		792,050	(753,837)	38,213			34
35	Rent-Equipment & Vehicles			31,074	31,074		31,074	8,640	39,714			35
36	Other (specify):* STORAGE			5,354	5,354		5,354		5,354			36
37	**TOTAL Ownership**			1,002,532	1,002,532		1,002,532	(332,493)	670,039			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		349,508	977,026	1,326,534		1,326,534		1,326,534			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,486	117,486		117,486		117,486			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		349,508	1,094,512	1,444,020		1,444,020		1,444,020			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,137,787	926,378	4,973,215	10,037,380		10,037,380	(1,600,332)	8,437,048			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,445)	30		9
10	Interest and Other Investment Income	(78,757)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,637)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(139)	21		18
19	Entertainment	(76,746)	20		19
20	Contributions	(7,739)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(250,307)	27		24
25	Fund Raising, Advertising and Promotional	(52,788)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,660)	20		28
29	Other-Attach Schedule	(29,852)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (526,070)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,074,262)	PG 6-6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,074,262)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,600,332)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DEERBROOK CARE CENTRE

ID# 0040741

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -1128	6	1
2	VACATION ACCRUAL	(2,326)	1	2
3	VACATION ACCRUAL	118	3	3
4	VACATION ACCRUAL	711	4	4
5	VACATION ACCRUAL	(563)	6	5
6	VACATION ACCRUAL	(24,723)	10	6
7	VACATION ACCRUAL	(1,478)	11	7
8	VACATION ACCRUAL	6,742	17	8
9		(7,205)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(29,852)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(2,326)	0	0	0	0	0	0	0	0	0	0	(2,326)	1
2	Food Purchase	(1,637)	0	0	0	0	0	0	0	0	0	0	(1,637)	2
3	Housekeeping	118	0	0	0	0	0	0	0	0	0	0	118	3
4	Laundry	711	0	0	0	0	0	0	0	0	0	0	711	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,691)	0	0	0	0	0	0	0	0	0	0	(1,691)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,825)	0	0	0	0	0	0	0	0	0	0	(4,825)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(24,723)	0	(15,507)	0	(29,735)	0	0	0	0	0	0	(69,965)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,478)	0	0	0	0	0	0	0	0	0	0	(1,478)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(26,201)	0	(15,507)	0	(29,735)	0	0	0	0	0	0	(71,443)	16
	C. General Administration													
17	Administrative	6,742	0	(402,914)	(300,849)	0	0	(100,283)	0	0	0	0	(797,304)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,000	(57,163)	44,771	634	(186,036)	0	0	0	0	0	(189,794)	19
20	Fees, Subscriptions & Promotions	(148,933)	0	606	174	19	252	0	0	0	0	0	(147,882)	20
21	Clerical & General Office Expenses	(7,344)	163	63,364	296	1,362	100,374	0	0	0	0	0	158,215	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,321	536	2,524	2,593	0	0	0	0	0	10,974	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	18,138	2,638	418	1,553	1,780	0	0	0	0	0	24,527	26
27	Other (specify):*	(250,307)	0	0	0	0	0	0	0	0	0	0	(250,307)	27
28	TOTAL General Administration	(399,842)	26,301	(388,148)	(254,654)	6,092	(81,037)	(100,283)	0	0	0	0	(1,191,571)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(430,868)	26,301	(403,655)	(254,654)	(23,643)	(81,037)	(100,283)	0	0	0	0	(1,267,839)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(16,445)	218,164	3,935	0	124	3,436	0	0	0	0	0	209,214	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(78,757)	282,247	0	0	0	0	0	0	0	0	0	203,490	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(792,050)	17,104	0	1,093	20,016	0	0	0	0	0	(753,837)	34
35	Rent-Equipment & Vehicles	0	0	4,341	514	1,739	2,046	0	0	0	0	0	8,640	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(95,202)	(291,639)	25,380	514	2,956	25,498	0	0	0	0	0	(332,493)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(526,070)	(265,338)	(378,275)	(254,140)	(20,687)	(55,539)	(100,283)	0	0	0	0	(1,600,332)	45

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		DEERBROOK NURSING CENTRE		
OWNERS		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 792,050	DEERBROOK NURSING CENTRE		$	$ (792,050)	1
2	V	19	ACCOUNTING		" "		8,000	8,000	2
3	V	26	MORTGAGE INSURANCE		" "		18,138	18,138	3
4	V	30	DEPRECIATION - BLDG IMP		" "		217,699	217,699	4
5	V	30	DEPRECIATION - EQPT & FN		" "		465	465	5
6	V	32	AMORTIZATION - MTG COST		" "		1,256	1,256	6
7	V	32	MORTGAGE INTEREST		" "		256,810	256,810	7
8	V	32	INTEREST - OTHER		" "		24,181	24,181	8
9	V	21	OFFICE EXPENSES		" "		163	163	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 792,050			$ 526,712	$ * (265,338)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 21,758	FHC ENTERPRISES INC.		$ 6,251	$ (15,507)	15
16	V	17	ADMINISTRATI VE	426,800	MR. BELLOWS OWNS 19% OF THIS FACILITY		23,886	(402,914)	16
17	V	19	PROFESSIONAL FEES	57,528	AND 100% OF FHC ENTERPRISES		365	(57,163)	17
18	V	20	DUES & SUBSCRIPTIONS				606	606	18
19	V	21	CLERICAL				63,364	63,364	19
20	V	24	TRAVEL				5,321	5,321	20
21	V	26	INSURANCE				2,638	2,638	21
22	V	30	DEPRECIATION				3,935	3,935	22
23	V	34	RENT				17,104	17,104	23
24	V	35	RENT - EQPT & VEH				4,341	4,341	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 506,086			$ 127,811	$ * (378,275)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		$ 44,771	$ 44,771	15
16	V	20	DUES & SUBSCRIPTIONS		" "		174	174	16
17	V	21	CLERICAL		" "		296	296	17
18	V	24	TRAVEL		" "		536	536	18
19	V	26	INSURANCE		" "		418	418	19
20	V	35	RENT - EQPT & VEH		" "		514	514	20
21	V	17	ADMINISTRATIVE	300,849	" "			(300,849)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 300,849			$ 46,709	$ * (254,140)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 68,238	CARLYLE NURSING ASSOCIATES, LLC		$ 38,503	$ (29,735)	15
16	V	19	PROFESSIONAL FEES		CARLYLE NURSING ASSOCIATES, LLC		634	634	16
17	V	20	DUES & SUBSCRIPTIONS		CARLYLE NURSING ASSOCIATES, LLC		19	19	17
18	V	21	CLERICAL		CARLYLE NURSING ASSOCIATES, LLC		1,362	1,362	18
19	V	24	TRAVEL		CARLYLE NURSING ASSOCIATES, LLC		2,524	2,524	19
20	V	26	INSURANCE		CARLYLE NURSING ASSOCIATES, LLC		1,553	1,553	20
21	V	30	DEPRECIATION		CARLYLE NURSING ASSOCIATES, LLC		124	124	21
22	V	34	RENT		CARLYLE NURSING ASSOCIATES, LLC		1,093	1,093	22
23	V	35	RENT - EQPT & VEH		CARLYLE NURSING ASSOCIATES, LLC		1,739	1,739	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 68,238			$ 47,551	$ * (20,687)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 191,301	THE KENSINGTON GROUP, LLC		$ 5,265	$ (186,036)	15
16	V	20	DUES & SUBSCRIPTIONS		THE KENSINGTON GROUP, LLC		252	252	16
17	V	21	CLERICAL		THE KENSINGTON GROUP, LLC		100,374	100,374	17
18	V	24	TRAVEL		THE KENSINGTON GROUP, LLC		2,593	2,593	18
19	V	26	INSURANCE		THE KENSINGTON GROUP, LLC		1,780	1,780	19
20	V	30	DEPRECIATION		THE KENSINGTON GROUP, LLC		3,436	3,436	20
21	V	34	RENT		THE KENSINGTON GROUP, LLC		20,016	20,016	21
22	V	35	RENT - EQPT & VEH		THE KENSINGTON GROUP, LLC		2,046	2,046	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 191,301			$ 135,762	$ * (55,539)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 100,283	CHESTERFIELD, LLC		$	$ (100,283)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 100,283			$ 0	$ * (100,283)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISE, INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	19%	SEE ATTACHED	0.18	1.17	SALARY	23,886	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,886		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	245,034	9	$ 46,961	$ 46,961	32,620	$ 6,251	1
2	17	ADMINISTRATIVE	PATIENT DAYS	245,034	9	193,005	193,005	32,620	23,886	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	245,034	9	2,739		32,620	365	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	245,034	9	4,554		32,620	606	4
5	21	CLERICAL	PATIENT DAYS	245,034	9	99,460		32,620	13,240	5
6	21	CLERICAL	DIRECT COST	1	1	50,124	50,124	1	50,124	6
7	24	TRAVEL	PATIENT DAYS	245,034	9	39,971		32,620	5,321	7
8	26	INSURANCE	PATIENT DAYS	245,034	9	19,813		32,620	2,638	8
9	30	DEPRECIATION	PATIENT DAYS	245,034	9	29,557		32,620	3,935	9
10	34	RENT	PATIENT DAYS	245,034	9	128,484		32,620	17,104	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	245,034	9	32,607		32,620	4,341	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 647,275	$ 290,090		$ 127,811	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WITTINGHAM MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	150,271	5	$ 213,094	$	31,576	$ 44,771	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	150,271	5	829		31,576	174	2
3	21	CLERICAL	PATIENT DAYS	150,271	5	1,408		31,576	296	3
4	24	TRAVEL	PATIENT DAYS	150,271	5	2,553		31,576	536	4
5	26	INSURANCE	PATIENT DAYS	150,271	5	1,990		31,576	418	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	150,271	5	2,448		31,576	514	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 222,322	$		$ 46,709	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	234,229	9	$ 285,631	$ 285,631	31,576	$ 38,503	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	4,705		31,576	634	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	142		31,576	19	3
4	21	CLERICAL	PATIENT DAYS	234,229	9	10,102		31,576	1,362	4
5	24	TRAVEL	PATIENT DAYS	234,229	9	18,724		31,576	2,524	5
6	26	INSURANCE	PATIENT DAYS	234,229	9	11,520		31,576	1,553	6
7	30	DEPRECIATION	PATIENT DAYS	234,229	9	917		31,576	124	7
8	34	RENT	PATIENT DAYS	234,229	9	8,109		31,576	1,093	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	12,901		31,576	1,739	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 352,751	$ 285,631		$ 47,551	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINGTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0053
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	$ 39,055	$	31,576	$ 5,265	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	1,870		31,576	252	2
3	21	CLERICAL	PATIENT DAYS	234,229	9	744,493	660,461	31,576	100,374	3
4	24	TRAVEL	PATIENT DAYS	234,229	9	19,234		31,576	2,593	4
5	26	INSURANCE	PATIENT DAYS	234,229	9	13,205		31,576	1,780	5
6	30	DEPRECIATION	PATIENT DAYS	234,229	9	25,492		31,576	3,436	6
7	34	RENT	PATIENT DAYS	234,229	9	148,483		31,576	20,016	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	15,176		31,576	2,046	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,007,008	$ 660,461		$ 135,762	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY DEERBROOK NURSING CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$61,407.35	12/03	4,775,900	4,732,655	12/38	5.4000	256,810	2
3	GMAC		X	LOAN COST	AMORT - 35 YEARS		43,959	42,644			1,256	3
4												4
5												5
	Working Capital											
6	BANK ONE		X	WORKING CAPITAL	DEMAND	DEMAND	416,200		VARIES	PRIME+	4,222	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	DEMAND	233,532	456,188	VARIES	VARIES	24,181	7
8												8
9	TOTAL Facility Related				$61,407.35		$ 5,469,591	$ 5,231,487			$ 286,469	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,469,591	$ 5,231,487			$ 286,469	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 89,724	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 88,433	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,291)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 89,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 752 For 1999 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (752)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 87,357	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	75,926	8
2000	79,847	9
2001	82,957	10
2002	88,752	11
2003	88,433	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DEERBROOK CARE CENTRE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040741

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-07-401-034-0000	NURSING HOME	$ 88,432.56	$ 88,432.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,432.56	$ 88,432.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,380 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	105,000	1975	$ 247,500	1
2	754 BASIS ADJ		1992	13,220	2
3	TOTALS	105,000		$ 260,720	3

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	214			1975	$ 1,849,704	$ 29,750	35	$ 52,849	$ 23,099	$ 1,544,756	4
5				1980	168,687		20			168,687	5
6	754 ADJ.			1992	125,584	3,987	31.5	3,987		49,839	6
7	754 ADJ.			2001	29,192	1,062	27.5	1,062		4,248	7
8											8
	Improvement Type**										
9	*****RELATED PARTY - DEERBROOK NURSING CENTRE***										9
10	IMPROVEMENTS			1984	33,823		20	849	849	33,823	10
11	IMPROVEMENTS			1986	21,535	1,120	20	1,077	(43)	19,924	11
12	IMPROVEMENTS			1987	78,860	4,314	20	3,943	(371)	69,448	12
13	IMPROVEMENTS			1988	48,614	1,768	31.5	1,544	(224)	25,132	13
14	IMPROVEMENTS			1989	60,430	2,197	31.5	1,919	(278)	30,525	14
15	IMPROVEMENTS			1990	30,485	1,108	31.5	967	(141)	13,677	15
16	IMPROVEMENTS			1991	53,134	1,931	31.5	1,688	(243)	22,656	16
17	IMPROVEMENTS			1992	117,363	3,725	31.5	3,725		45,939	17
18	IMPROVEMENTS			1993	29,335	932	39	932		11,035	18
19	IMPROVEMENTS			1993	29,864	767	27.5	767		8,693	19
20	IMPROVEMENTS			1994	37,711	1,371	27.5	1,371		14,150	20
21	VINYL SLIDER UNITS			1995	3,070	112	27.5	112		1,059	21
22	DOORS			1995	2,564	93	27.5	93		880	22
23	ROOF			1996	24,069	875	27.5	875		7,474	23
24	OUR TOWN			1996	74,400	2,705	27.5	2,705		21,753	24
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS			1997	448,432	16,005	27.5	16,005		118,448	25
26	ALZHEIMERS WING CONSTRUCTION			1997	1,590,575	57,833	27.5	57,833		423,552	26
27	OUR TOWN			1998	21,500	782	27.5	782		5,441	27
28	ALZHEIMERS WING CONSTRUCTION - FINAL DRAW			1998	17,009	618	27.5	618		4,301	28
29	DINING ROOM FLOOR - TILES			1998	30,000	1,091	27.5	1,091		7,592	29
30	DOOR ALARM SYSTEMS			1998	24,760	900	27.5	900		6,263	30
31	SPRINKLERS			1998	3,500	127	27.5	127		884	31
32	DINING ROOM - WALLPAPER/TILE BASE			1998	14,900	542	27.5	542		3,726	32
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS			1998	9,400	342	27.5	342		2,323	33
34	REMODELING OF ELEVATOR - LOBBY			1998	7,050	256	27.5	256		1,718	34
35	LANDSCAPING			1998	2,815	102	27.5	102		685	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ROOF TOP PTAC UNITS	1998	$ 3,508	$ 128	27.5	$ 128	$	$ 858	37
38	DINING & RESIDENT ROOM FLOORS	1998	15,268	555	27.5	555		3,677	38
39	HOT WATER TANK	1998	1,780	65	27.5	65		430	39
40	REMODELING - SHOWER ROOM	1998	3,830	139	27.5	139		886	40
41	ASPHALT PARKING LOT & SPEED BUMPS	1998	17,156	624	27.5	624		3,874	41
42	WALLCOVERING/WINDOW TRMTS/TILES	1998	18,635	678	27.5	678		4,209	42
43	REMODELING - RESIDENT ROOMS	1998	37,050	1,347	27.5	1,347		8,137	43
44	WINDOW TREATMENTS/REMODEL RMS	1999	18,066	657	27.5	657		3,915	44
45	FIRE ALARM & HVAC/CEILING/HALLS/CALL LIGHTS	1999	25,000	909	27.5	909		5,341	45
46	REPAIR & REMODEL HALLWAY/DOOR MONITOR SYS	1999	23,425	852	27.5	852		4,934	46
47	REMODEL ROOMS/DOOR MONITOR SYS	1999	45,989	1,672	27.5	1,672		9,545	47
48	REMODEL RMS/LANDSCAPING	1999	53,572	1,948	27.5	1,948		10,958	48
49	WALLCOVERING/WINDOW TRMTS/TILES	1999	6,950	253	27.5	253		1,402	49
50	REMODELING RMS	1999	16,205	589	27.5	589		3,215	50
51	WALLCOVERING/FLOOR TILES/HANDRAILS	1999	28,464	1,035	27.5	1,035		5,563	51
52	REMODELING RMS	1999	47,115	1,713	27.5	1,713		9,065	52
53	NURSE STATION/ELEVATOR DOOR	1999	18,030	656	27.5	656		3,417	53
54	REMODELING ROOMS/WINDOW TRMTS	1999	170,712	6,207	27.5	6,207		31,294	54
55	FIRE DAMPERS	2000	4,950	180	27.5	180		893	55
56	REMODELING - WASHROOMS/MEDICAL & REC. RM	2000	35,550	1,293	27.5	1,293		6,195	56
57	FENCES	2000	3,557	129	27.5	129		608	57
58	WALLCOVERING/WINDOW TRMT - RES & DINING RMS	2000	69,939	2,543	27.5	2,543		11,550	58
59	FIREWALL/RESIDENT ROOM CEILINGS/TUCKPOINTING	2000	85,160	3,096	27.5	3,096		14,062	59
60	MAGNETIC DOOR/STEAMER	2000	16,334	451	27.5	451		2,126	60
61	HANDRAILS	2000	8,101	295	27.5	295		1,315	61
62	REMODELING - NURSE STATION/CORRIDOR/DINING RM	2000	126,731	4,608	27.5	4,608		20,545	62
63	PTAC UNITS	2000	3,550	129	27.5	129		575	63
64	CONCRETE PAVING	2000	11,700	425	27.5	425		1,895	64
65	IRRIGATION SYSTEM & ROOM PLATES	2000	10,425	379	27.5	379		1,658	65
66	DESIGN & BUILD ENABLING GARDEN	2000	19,832	1,323	15	1,323		5,952	66
67	CARPETING/WINDOW TREATMENT	2000	14,549	529	27.5	529		2,270	67
68	PTAC UNITS	2000	3,550	129	27.5	129		554	68
69	REMODELING-BREAK ROOM, MEDICATION RM	2000	39,886	1,450	27.5	1,450		6,223	69
70	TOTAL (lines 4 thru 69)		$ 5,992,934	$ 173,401		$ 196,049	$ 22,648	$ 2,855,772	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,992,934	$ 173,401		$ 196,049	$ 22,648	$ 2,855,772	1
2	SIDEWALK	2000	2,240	81	27.5	81		341	2
3	REMODELING - RESIDENT RMS, LOBBY, MAILROOM	2000	60,826	2,212	27.5	2,212		9,309	3
4	PTAC UNITS	2000	4,644	169	27.5	169		711	4
5	WOOD BLINDS FOR OFFICES	2001	3,538	129	27.5	129		510	5
6	CUBICLES	2001	8,332	303	27.5	303		1,199	6
7	REMODEL - ALL 2ND FLOOR RESIDENT ROOMS	2001	370,353	13,466	27.5	13,466		53,305	7
8	VERTICAL BLINDS FOR 2ND FLOOR ROOMS	2001	3,847	140	27.5	140		554	8
9	CARPETING FIRST FLOOR OFFICES/PLUMBING	2001	8,850	322	27.5	322		1,221	9
10	DROP & CHANGE SPRINKLER HEADS IN CORRIDOR	2001	5,097	185	27.5	185		686	10
11	REPAIR CEILING ON FIRST FLOOR	2001	25,000	909	27.5	909		3,371	11
12	REPAIR CORRIDOR IN LAUNDRY AREA	2001	10,000	364	27.5	364		1,289	12
13	TEN TON COMPRESSOR FOR KITCHEN UNIT	2001	4,441	161	27.5	161		530	13
14	INSTALL TILE FLOORING IN SERVICE HALLWAY	2002	11,300	411	27.5	411		1,216	14
15	INSTALL ELECTRICAL OUTLETS IN RMS 101 TO 110	2002	8,000	291	27.5	291		740	15
16	INSTALL PIPE RUN FR. ELECTRICAL CLOSET TO RM 104	2002	1,186	43	27.5	43		109	16
17	FRIEDRICH 11700 BTU PTAC UNITS - 2	2002	1,337	49	27.5	49		124	17
18	AMANA-PTAC 12000 BTU HEAT & 11700 PTAC UNIT	2002	1,379	50	27.5	50		123	18
19	REPLACE FIRE PANEL	2003	4,500	164	27.5	164		267	19
20	2 CANVAS AWNINGS	2003	1,650	110	15	110		124	20
21	RESTRIP AND ASPHALT SEAL PARKING LOT	2003	6,535	436	15	436		490	21
22	INSTALLATION OF 4 BATHRM WATER SHUT OFF VALVES	2004	2,360	82	27.5	82		82	22
23	WIRING AND INSTALLATION OF TV'S IN RES. ROOMS	2004	20,700	471	27.5	471		471	23
24	CONCRETE WORK DONE TO B WING SIDE WALK	2004	5,540	109	27.5	109		109	24
25	REPAIR/REPLACEMENT OF ELECTRICAL LIGHTING COM	2004	7,350	145	27.5	145		145	25
26	INSTALL 80 SOLID CORE, FIRE RATED DOORS	2004	75,115	797	27.5	797		797	26
27	INSTALL NEW ELECTRICAL WIRING & PIPING - 1ST FLR	2004	33,552	51	27.5	51		51	27
28									28
29			ADJ TO SL	22,648			(22,648)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,680,606	$ 217,699		$ 217,699	$	$ 2,933,646	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 626,698	$ 54,120	$ 63,667	$ 9,547	3-10 YRS	$ 305,649	71
72	Current Year Purchases	47,258	28,355	2,363	(25,992)	3-10 YRS	2,363	72
73	Fully Depreciated Assets							73
74	RELATED PARTIES		7,960	7,960				74
75	TOTALS	$ 673,956	$ 90,435	$ 73,990	$ (16,445)		$ 308,012	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,615,282	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 308,134	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 291,689	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (16,445)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,241,658	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 27,532 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	$ 295.13	$ 3,542	17
18					18
19					19
20					20
21	TOTAL		$ 295.13	$ 3,542	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 437,656	$		$ 437,656	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			108,623			108,623	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			430,136			430,136	4
5	Physician Care	39-3	visits			611			611	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				250,620		250,620	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, I.V. THERAPY Other (specify): RENTALS	39-2					98,888		98,888	13
14	TOTAL			$		$ 977,026	$ 349,508		$ 1,326,534	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 572,349	$ 1,027,841	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,181,145	2,181,145	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,548	122,324	6
7	Other Prepaid Expenses	34,161	34,161	7
8	Accounts Receivable (owners or related parties)	104,820	132,820	8
9	Other(specify): ESCROW DEPOSITS		741,868	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,948,023	$ 4,240,159	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	928,437	646,249	11
12	Long-Term Investments	1,955	1,955	12
13	Land		247,500	13
14	Buildings, at Historical Cost		1,849,704	14
15	Leasehold Improvements, at Historical Cost		4,663,959	15
16	Equipment, at Historical Cost	675,322	791,131	16
17	Accumulated Depreciation (book methods)	(579,477)	(3,475,482)	17
18	Deferred Charges		42,644	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROG.		2,386	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,026,237	$ 4,770,046	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,974,260	$ 9,010,205	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 871,615	$ 561,213	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	295,029	295,029	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,980	90,980	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,204	13,204	31
32	Accrued Real Estate Taxes(Sch.IX-B)		89,400	32
33	Accrued Interest Payable		21,297	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO DPA	40,390	40,390	36
37	MANAGEMENT FEES	2,730	2,730	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,313,948	$ 1,114,243	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		174,000	39
40	Mortgage Payable		4,732,655	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,906,655	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,313,948	$ 6,020,898	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,660,312	$ 2,989,307	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,974,260	$ 9,010,205	48

*(See instructions.)

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,347,980	1
2	Restatements (describe):		2
3	ROUNDING ADJ	1	3
4	REPLACEMENT TAX	(3,084)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,344,897	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	415,415	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 315,415	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,660,312	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,385,510	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,385,510	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	78,757	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 78,757	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,464,267	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,143,748	31
32	Health Care	3,361,630	32
33	General Administration	3,085,450	33
	B. Capital Expense		
34	Ownership	1,002,532	34
	C. Ancillary Expense		
35	Special Cost Centers	1,326,534	35
36	Provider Participation Fee	117,486	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS	11,472	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,048,852	40
41	**Income before Income Taxes (line 30 minus line 40)****	415,415	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 415,415	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,775	2,384	$ 99,197	$ 41.61	1
2	Assistant Director of Nursing	2,361	2,798	85,810	30.67	2
3	Registered Nurses	35,050	36,874	1,107,675	30.04	3
4	Licensed Practical Nurses	21,584	22,728	498,269	21.92	4
5	Nurse Aides & Orderlies	90,988	95,539	989,312	10.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,971	5,401	110,680	20.49	9
10	Activity Assistants	10,449	10,888	81,939	7.53	10
11	Social Service Workers	1,923	2,083	34,838	16.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,513	11,154	151,313	13.57	14
15	Cook Helpers/Assistants	15,853	16,673	114,515	6.87	15
16	Dishwashers					16
17	Maintenance Workers	6,057	6,618	84,659	12.79	17
18	Housekeepers	15,422	16,389	131,123	8.00	18
19	Laundry	12,544	13,458	89,330	6.64	19
20	Administrator	1,958	2,230	128,641	57.69	20
21	Assistant Administrator	821	931	25,590	27.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,163	22,299	374,201	16.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,984	2,138	30,695	14.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	254,416	270,585	$ 4,137,787 *	$ 15.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 12,590	1-3	35
36	Medical Director	98	9,150	9-3	36
37	Medical Records Consultant	13	938	10-3	37
38	Nurse Consultant	1,380	97,797	10-3	38
39	Pharmacist Consultant	192	4,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47	PSYCHOLOGIST	83	6,818	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,958	$ 131,493		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY DUMONT	ADMIN		$ 128,641
KATHY SMITH	ASST ADMIN		25,590
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 154,231

B. Administrative - Other

Description		Amount
RELATED ENTITIES	MANAGEMENT FEES	$ 827,932
TOTAL (agree to Schedule V, line 17, col. 3)		$ 827,932
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		302,021
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 302,021

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 84,201
Unemployment Compensation Insurance		40,854
FICA Taxes		308,322
Employee Health Insurance		194,078
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		11,367
EMPLOYEE PHYSICAL EXAMS		2,900
PENSION/PROFIT SHARING PLANS		8,919
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 650,641

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,016
Health Care Worker Background Check	596
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	141,194
TRUST/FRANCHISE/CONTRIB/ETC	7,739
LICENSES & PERMITS	1,656
DUES & SUBSCRIPTIONS	9,440
MGMT CO ALLOCATION	1,051
TRUST/FRANCHISE/CONTRIB/ETC	(7,739)
Less: Public Relations Expense	(76,746)
Non-allowable advertising	(52,788)
Yellow page advertising	(11,660)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,759

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	193
RELATED PARTY	10,974
Seminar Expense	
	3,209
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,376

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	06/2001	$ 2,061	3	$ 344	$ 687	$ 687	$ 343	$	$	$	$	$
2	PAINT/DECORATING	06/2004	1,765	3				294	588	588	295		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,826		$ 344	$ 687	$ 687	$ 637	$ 588	$ 588	$ 295	$	$

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Il. COUNCIL ON LONG TERM CARE - $12186.72**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,889** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **117,486**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees